

COMMENTARY

NICE guidance and the National Chlamydia Screening Programme

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The UK National Institute for Health and Clinical Excellence (NICE) public health guidance on interventions for the prevention of STI and under-18 conceptions¹ follows consultation and the commission of three reviews, including a rapid review of the evidence for the effectiveness of screening for genital chlamydia infection in sexually active men and women.² This review found evidence from two randomised trials that register-based screening (where eligible individuals are identified from a population register, such as a general practice list, and invited to undergo screening) could reduce the incidence of pelvic inflammatory disease (PID) by about half at 1 year. However, the review found no trials of the effectiveness of opportunistic screening (where screening is offered to eligible individuals attending healthcare settings for any reason) which is the main approach of the National Chlamydia Screening Programme (NCSP) in England.

Why then, are there no recommendations for practice or research in the NICE guidance that relate to chlamydia screening and what should happen now? Part of the explanation may lie in the guidance scope, which was restricted to one-to-one interventions. 'Screening' an individual for chlamydia infection may be regarded as case-finding through a one-to-one intervention, but the NCSP aims at population level "to control genital chlamydia infection through the early detection of asymptomatic infections and prevention of sequelae and onward transmission".³

The positive findings of the review in relation to register-based chlamydia screening and the contrasting lack of

evidence in relation to opportunistic screening raise important and uncomfortable questions about the evidence base for the NCSP, which should be tackled urgently. If this is beyond the remit of NICE, then it should fall to the National Screening Committee (NSC), which assesses screening programmes to ensure that they do more good than harm at a reasonable cost. In 1996, the NHS was instructed not to introduce any new screening programmes until the NSC had reviewed their effectiveness. Current NCSP performance indicators do not include measures of repeat testing or clinical complications, thus it is unclear how the success of the programme in reducing morbidity can be assessed adequately. Contrary to previous suggestions,⁴ we should not rely on the proportion of screened individuals with a positive chlamydia test (as a proxy for chlamydia prevalence) over time to indicate the effectiveness of the NCSP because of the inherent weakness of attributing causation to uncontrolled time trends; changes over time in the proportion of screened persons with chlamydia could be due to changes in sexual risk behaviour rather than the effects of screening.^{5,6} Moreover, the proportion of people who test positive in the NCSP is likely to fall over the next couple of years as screening coverage increases and more low-risk (uninfected) people are screened; this does not in itself mean that screening is effective in reducing the burden of infection or any resulting morbidity in the population.

The lack of recommendation for research in relation to chlamydia screening is a strange omission from the NICE guidance. As the NCSP is being rolled out across England, there may still be a

window of opportunity to evaluate the effectiveness of different screening approaches (opportunistic, systematic or combined) in controlled trials, with chlamydia prevalence and pelvic inflammatory disease in stable populations as trial endpoints. Infertility and ectopic pregnancy are too remote or uncommon events to be trial endpoints, but research should examine the feasibility of data linkage studies to enable the incidence of these clinical events to be estimated in large numbers of women with known screening histories. We also need high quality, innovative research to improve the accuracy of PID diagnosis, or else continue to spend many millions on screening to prevent a condition that we cannot detect adequately. These are not easy topics for research, and they will require investment, but if we want to do better than countries like Sweden and the USA, which have not brought Chlamydia under control despite years of extensive opportunistic screening,⁶ we need to take a fresh look at screening for genital chlamydia infection in the UK.

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Competing interests: I am co-author of a NICE-commissioned review of chlamydia screening and have tried unsuccessfully to get funding for a large trial of chlamydia screening.

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